PERSONNEL CABINET
GROUP LIFE INSURANCE ADMINISTRATION
REFUND REQUEST

NAME: _____

SS#: _____

LOCATION NAME: _____

LOCATION #: _____

AMOUNT BEING REQUESTED: _____

PREMIUM PERIOD: _____

REASON FOR REFUND: _____

_____

REQUESTED BY: _____

DATE REQUESTED: _____

***ALL REFUND REQUESTS WILL BE MAILED TO THE INSURANCE COORDINATOR UNLESS OTHERWISE REQUESTED.

MAIL OR FAX REQUEST TO: PERSONNEL CABINET
GROUP LIFE INSURANCE ADMINISTRATION
200 FAIR OAKS LANE, ROOM 503
FRANKFORT, KY 40601
(502) 564-4774 OR (502) 564-4034 - FAX